Clear Fields

# HEALTH TRACKS APPOINTMENT SLIP

ND Department of Human Services

SFN 705 (02-2006)

| | | | |
|---|---|---|---|
| Screenee's Name: | | | |
| Appointment Date and Time: | | | |
| Provider's Name: | | Telephone Number: | |
| Street Address: | City: | State: | Zip: |
| Comments: | | | |
| IMPORTANT: | If you are unable to keep this appointment please call _____. | | |
| County Worker's Name: | County: | Telephone Number: | |
| REMEMBER: If you need help with transportation, please call your local county service office. | | | |

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Canary Copy - File


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